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Gender Identity Disorder in a Five-Year-Old Boy

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Markedly effeminate behavior in a young boy is a source of concern and confusion for parents, teachers, and the child. It also represents a therapeutic dilemma for the child psychiatrist. The case of a five-year-old boy with gender identity disorder of childhood is presented and the literature on hypotheses of etiology, treatment, and long-term follow-up is reviewed. The ethical and philosophical questions posed by such a case are discussed.

Today we may be used to seeing adults evincing "alternative" sexual life styles or adopting certain affectations—often greatly exaggerated—of the other sex. However, it is rare to see such behavior in a small child. A five-year-old boy displaying markedly effeminate behavior in his play and interpersonal relationships and expressing outright his desire to be a girl is a source of concern to those around him and an enigma to the child psychiatrist. If homosexuality per se is no longer considered a disorder by the American Psychiatric Association (although the debate goes on), what is to be made of a little boy cross dressing with his mother's clothes, swinging his hips, pronating his wrists, and declaring his intention to grow up to be Batgirl?

This paper discusses the evaluation and psychotherapy of such a child who, in addition to the aforementioned behavior traits, had failing peer relationships with both sexes and was extremely unhappy at being teased by other children. The developmental history of the child is presented, and the family and parents' biography is included as well. The working hypotheses employed by the child psychiatrist for this case are discussed as is a course of psychotherapy for the child. Finally, the psychiatric disorder itself, gender identity disorder of childhood, is reviewed.

CASE REPORT

Fred was five and one-half years old when first seen at the Yale Child Study Center. He was brought in a bit reluctantly by his parents at the strong urging of his kindergarten teacher. She believed the child was "well on his way to becoming a homosexual." Fred's mother said that her child had "an identity problem"; that is, he took the woman's part in most play activity and seemed obsessed with the Batgirl character. Since age three years he had displayed certain feminine behavior patterns: insisting on being "the mommy" in nursery school play, cross dressing in his

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mother's shoes and skirts, playing with her jewelry, and carrying her pocketbook. At age four he assumed certain feminine hand gestures and a woman's gait and at four and one-half years began his preoccupation with Batgirl. He eschewed all play with toy trucks or cars, avoided "horse play" with other boys, and preferred the company of his mother and neighborhood girls. He did not get along with his classmates, being very imperious and a nuisance. Similarly, he fought frequently with his teenage siblings. Fred's mother, Mrs. P., had known for two years that Fred was "different"; she was worried. His father thought his son's behavior was "cute" and "just a phase."

The history revealed that Fred was the product of a full-term uncomplicated planned pregnancy. His mother, married twice before, had two children by her first marriage. His father, married once before, had three children. Mother took no hormones or other drugs during the gestation. Fred weighed six pounds seven ounces at birth and did well as a neonate. When he was three weeks old Mrs. P. resumed her job as a night radio dispatcher. Because she slept during the day, her son was cared for by his grandmothers with whom he stayed for various periods of time. Fred's developmental milestones were all within normal limits.

When Fred was three years old, he attended a day care center seven hours a day and apparently did quite well. Sometime during this year, however, Mrs. P. learned of her husband's infidelity. Angry and humiliated, she left her job and turned all her attention toward her three children. A very close relationship developed with her son, Fred. Withdrawing much of her affection and severing for several months sexual relations with her husband, she became extremely attached to Fred. She took him everywhere, constantly caressed and embraced him, cried to him, talked to him about her marital problems, and even slept alone with him. She did not, however, engage in any overt sex play with him.

Although the parents were reconciled after several months, Mrs. P. continued what she called her "special relationship" with Fred. In his fourth year, her son was noted to prefer "helping" his mother in the kitchen to playing with other children. He dusted around the house, swept, and became interested in girls' and women's clothing. For this he was teased by Mr. P., who greeted him at the end of the day with "How's my little girl?" (Both parents stated during the evaluation that they had been hoping for a girl from this pregnancy.) Fred continued to sleep with his parents on occasion or alone with his mother after father left for work.

Mrs. P., in her early thirties, was a housewife. Both her parents were alcoholic and a sister was a lesbian. She became pregnant, dropped out of school, and was first married at age 16. She reported she suffered verbal and physical abuse from her husband. The marriage lasted four years. A second marriage lasted two years. When she met her present husband, she was abusing alcohol and illicit drugs. Mr. P., a high school graduate, has worked steadily in a factory. In his mid-forties, he has a male first cousin who is homosexual. Fred has never met him. Mr. P. admittedly likes to satirize homosexuals at parties. He denied any homosexual experiences.

During the evaluation, Fred presented as a very attractive, articulate, and cooperative child. He readily separated from his parents and eagerly explored the playroom. His eyelashes were strikingly long and his skin was like porcelain. His gait seemed to mimic a woman's. He would thrust his hips about and gesture at his wrist as he spoke. His facial expressions also seemed greatly exaggerated. The overall effect from this five-and-one-half-year-old boy was decidedly bizarre. Yet, he was immediately likeable and possessed speech and language skills above average for his

age. While displaying a full range of affect, he expressed sadness over his inability to make friends.

The examiner discussed with Fred the reasons for his evaluation. Fred said he liked Batgirl and wanted to be like her. He said that he wanted to keep his penis because "girls have them too." His three wishes were: (1) to have a lot of gold, (2) to be a girl, and (3) to be Batgirl. He did not wish to discuss his playing the role of the girl and in fact became annoyed at the examiner when pushed on this point. All higher cortical functions were intact. When asked to draw a person, he drew a decidedly feminine figure that he said was a boy. But after a few moments' reflection, he wrote "Batgirl" across the page.

Some working hypotheses were generated in order to guide therapy. First, it appeared that Fred demonstrated gender *confusion*. The choice of the Batgirl character was significant in that this is a very strong, aggressive, and "masculine" fantasy figure. It was not Cinderella or Snow White. This suggested that his gender identity was not settled. Second, the multiple female caretakers in Fred's early years might have had a profound impact on his early identification and need to feel protected. Third, his father's affair and his mother's subsequent turning toward him for affection and solace might have been exceedingly stimulating to Fred and confusing as well. Fourth, as a result of his mother's seductive behavior Fred may have resorted to the unconscious ego defense mechanism of identification with the aggressor [1]. That is, he might have begun to identify himself with his mother to protect himself from castration fantasies. Thus, acting as a woman he would not then need to fear the loss of his penis. Fifth, the father's shadowy role in Fred's early years and his disappointment at not having a girl left the child surrounded by female role models in his mother and two grandmothers. There was no balance because of the father's peripheral involvement. Sixth, both parents unconsciously have colluded with Fred's symptoms: father by minimizing them and mother by accepting them for a time because they allowed Fred and herself to remain with their "special relationship." Seventh, Fred himself might have received some secondary gain by his symptoms; that is, they may have served to disguise anger he could have felt at his mother's intrusiveness while still attracting attention to himself and involving her with him.

These hypotheses guided the treatment which involved seeing Fred in psychotherapy twice a week and his parents together once a week. In the beginning of the treatment Fred was constricted in his play, making sure he did not mess his hands. He refused to discuss anything relating to his effeminacy. However, he did speak openly of his inability to make or retain friends. As therapy progressed he became "messier" during the sessions and at home as well. After two months he no longer was speaking of Batgirl and in general his effeminate behavior was markedly reduced. He was making more of an effort to get along with neighborhood children. A bit later the family's move to another town excited Fred with the opportunity to make new friends. He brought his excitement and apprehensions about his new school into the therapy sessions, often playing very aggressively and enacting the role of a domineering, angry teacher with the therapist asked to play the role of the docile student. Only occasionally would he discuss his earlier gender confusion, still feeling uncomfortable with that issue. However, he was no longer insisting on girls' roles in school nor was he "mother's little helper" at home.

The parents were helped to see how they had been colluding separately and together in their son's behavior problems. They learned how their own sense of self

and sexual identity (based upon their early childhood experience and subsequent adult roles) were intimately connected with their son's confusion about who he was. Fred's mother was able to "let go" of her son enough to encourage his growth and independence. His father became more involved qualitatively and quantitatively with Fred—to their mutual surprise and delight. In this way Fred's esteem as a young boy was gradually raised. His school and interpersonal successes were a source of pride for Fred and his parents and contributed to his much improved sense of self.

DISCUSSION

This case is illustrative of the rare but fascinating gender identity disorder of childhood. Fred fit the major diagnostic criteria in boys for this syndrome [2]: desire to be a girl, preoccupation with female activities (including cross dressing), and onset before puberty. A number of theories—primarily based upon psychoanalytic insights—have been promulgated for this disorder. Stoller [3] differentiated boys displaying pure femininity from those who are effeminate or who appear to mimic female behavior from an early age. The first group which he labelled as "natural-appearing femininity" has its origins, according to Stoller, in the first year of life. This type of behavior he wrote "[is] promoted primarily by a mother-infant symbiosis in which mother's avowed purpose is to prevent her son from suffering pain or frustration. She tries to create a blissful ambiance. At the same time the boy's father is not present to drive a wedge that would promote separation between the mother and infant and allow that individuation we call masculinity to occur. This family dynamic produces the most feminine of boys, the childhood transsexual . . ." [3]. According to Stoller, the feminine boys have no oedipal conflicts because they have never developed any sense of maleness or need to separate from their mother. Theirs is a desire to *be* a mother—not to *have* her. In these cases father is not perceived as a rival and there is no need for male genitals. The child may state to his family that he *is* really a girl, will grow up to be a woman, or wants help in becoming a girl.

The second group of boys, according to Stoller [3], may display marked effeminate behavior and often comprises, in later years, homosexuals, transvestites, and some transsexuals. These boys, having experienced disturbances in their early development, nevertheless have been able to separate to some extent from their mothers' bodies and psyches. Yet they feel threatened by a "smothering" mother and are in great conflict ". . . between wanting to be merged with or at least close to mother and wanting to be separate; between wanting to be like and to be different from her; between wanting to stay (to be passive) and to move (to be active)" [3]. This group of boys uses mimicry to camouflage rage and revenge at the mother. The boys in addition may deny their castration fears through identification with a strong, aggressive ("phallic") woman, as Fred did with Batgirl [3].

In a longitudinal study of 60 effeminate boys begun when they were ages four to eleven years, Green [4] found these children to be loners, rejected by their peers. Ninety-eight percent cross dressed and 83 percent wished that they had been born female. They tended to avoid rough-and-tumble play, preferred their mothers' company, and were emotionally distant from their fathers.

Green [5] has provided a schema for understanding the etiology of this disorder in boys. It is a schema based upon interpersonal and intrapsychic dynamics as follows: initially the mother finds her child to be particularly "beautiful" and quite responsive to being held and caressed by her. She spends a lot of time with the child who is often separated in a number of years from his other siblings. Thus he may achieve

relative "only child" status in the family. For various reasons mother may have few other outlets for her affection. The child comes to identify with the mother as a result of this closeness and wants to be like her. This early behavior is seen as "cute" by both parents. The father may not be available to his son to provide that "wedge" described by Stoller [3]. The boy goes on to prefer playing with girls and may avoid the father who then feels rejected and backs away even more. Although the child comes to be teased by other boys, his mother reinforces his behavior in order to keep him close to her. As the gap between father and son widens, father may minimize the son's behavior, saying "It's just a phase." Finally, the boy takes on increasingly feminine affectations. Remarkably, this sequence of events outlined by Green [5] closely parallels a number of Fred's early life experiences.

Pruett and Dahl [6] describe the toddler at risk as ambivalent about separating from mother. Mother's femininity becomes internalized in the child and the symptom complex of feminine behavior serves to reduce anxiety about separation as well as to defend against aggressive feelings he may have.

While a number of psychological and interpersonal hypotheses have been generated about the etiology of gender identity disorder of childhood, the unanswered question remains about the role of biological processes. Neuroendocrine animal research has stimulated interest in this area. For example, a female rhesus monkey exposed *in utero* to high levels of exogenously administered testosterone demonstrated virilized external genitalia as well as behavioral effects [7]. Similarly, in humans, females born with adrenogenital syndrome have been found to be significantly more "tomboy-ish" than normal controls [8]. Biological factors have been implicated in the etiology of homosexuality in a recent study sponsored by the Kinsey Institute. In a study of 979 homosexual and 477 heterosexual men and women, Bell, Weinberg, and Hammersmith [9] concluded that sexual preference is not consistently linked to early childhood experiences and relationships with mother, father, siblings, or peers. They concluded in this retrospective study based upon interviews with adults that the only possible explanation for homosexual behavior rests with as yet unknown biological factors. The study has been criticized for its particular statistical methodology and the lack of hard evidence supporting its conclusions [10]. Nevertheless, the controversy rages on. Perhaps what is needed is an interaction theory as called for by Green [11] in which biological factors and subsequent socialization experiences could be viewed as affecting each other and the child as development proceeds.

Just as etiological explanations for this type of behavior in boys remain unsettled and controversial, the issue of treatment is also viewed variously by different therapists. In fact, one may even question whether or not this behavior represents a true disorder or just a normal variant of childhood. Should these children—who appear to be so different because they do not conform to society's traditional standards of sex role behavior—be considered "disturbed" and referred for treatment? Could the problem be with a too-rigid culture that rewards stereotyped behavior and punishes the "follower of the different drummer"? After all, in a number of cultures around the world, including certain North American Indian tribes, young males adopting feminine behavior traits have been accorded special status and are not considered outcasts [5]. Further, the great leaps made in sex role behavior within our own country in recent years may complicate the question of whether such children need treatment. It may soon be "OK" for boys to avoid rough sports if they want to and cook and help with housework. Similarly, girls now can wish to participate in

football, get dirty, and want to be pilots and doctors when they grow up. As Green [11] states, "As societal (herein translated as parental) expectations change, there should also be fewer children (especially males) who do not meet the behavioral expectations of their fathers." However, Green [11] points out the difference between gender behavior and identity and stresses that there may still exist a sub-group of children who, for various reasons, assume a cross sex identity. For these children, societal changes and cultural norms have less impact upon their own intrapsychic conflicts.

Treatment intervention raises many ethical issues [11]. Is the problem here with a repressive, stagnant society placing unnatural behavioral demands upon its children? Should not society change and should not children be protected from therapy which could be viewed as merely an extension of society's repression? Would not such children be susceptible to even greater psychological harm? On the other hand it has been argued that such children *are* in conflict, are considered outcasts by their peers, and have very worried parents and teachers. In addition, it might be argued that our society is not advancing fast enough for this group of unusual children and that life will only become harder and they will become unhappier as they get older.

If the child is taken to the therapist, it then rests with the professional to weigh all sides of this complex issue, to consider the ethical questions raised here and—most important—to properly assess the particular child and family presenting in order to arrive at a plan.

Treatment programs for these children vary considerably. Stoller [3] sees the therapist encouraging masculine interests in the child and treating the parents as well. Mother must be helped to avoid sabotaging the therapy and to let the child go—to "free him from her embrace." Green [5] believes that with guidance parents can act as ancillary therapists for the child. In addition, he believes that the father-son relationship should be enhanced. Bates et al. [12] have used parent-and-child groups. They stress improving social skills and peer interaction as they work with families. With some boys they have used behavioral therapy to reinforce masculine behavior. Pruett and Dahl [6], on the other hand, caution against emphasizing the extinguishing of symptoms. They state that such efforts may put unnecessary pressure on the child. They stress the importance of family work.

Questions may also be raised as to which treatment regimes are effective. Further, one might well ask what constitutes "successful" therapy. Is the goal to make the child more masculine, conceivably to prevent later homosexuality? Or, should the goal be to help these children feel more comfortable with their biologic make up—or core morphologic identity—so that they may make freer choices of sexual partners as adults [11]? There are no clear answers to these questions. While most boys in treatment of various sorts do become more masculine in behavior, how this relates to later sexual life and gender identity is unknown [11]. Outcome studies of such boys suggest that a certain percentage do go on to become homosexual or bisexual. Bieber [13] studied 100 male homosexuals in psychotherapy, and one-third gave a history of feminine childhood behavior. Saghir and Robins [14] and Whitam [15] also obtained similar histories from their homosexual subjects. Zuger [16] reported long-term studies of 16 effeminate males followed from ten to 22 years after the first visit. Eight of these boys were known to have become homosexual in childhood. Money's [17] group of 12 patients included five adult homosexuals and Green's [4] longitudinal study of 60 boys has revealed four out of eleven adolescents studied so

far have homosexual as well as heterosexual fantasies when they masturbate. Five have had bisexual experiences and one is described as an adolescent "drag queen." This study is ongoing.

It is of course impossible to predict the outcome of Fred's gender identity confusion. Longitudinal studies, varied as they are in patient population and criteria, nevertheless suggest that some of these boys become homosexual or bisexual. Whether psychiatric intervention early on affects ultimate gender role is also not known. However, early intervention is justified to help these generally unhappy children sort out their intrapsychic confusion and to assist them in their interpersonal relationships. The goals should not simply be heterosexuality but rather helping these children develop into adults capable of making a healthier, less neurotic choice about their ultimate sexual identity.

To this end, Fred's treatment has proceeded reasonably well. Several factors may be responsible. First, it was possible to establish a warm, non-neurotic, and accepting therapeutic milieu into which Fred could safely bring his troubles and be himself. Second, in this case Fred's symptoms were not fixed and immutable. Whatever constitutional factors existed were open to change and revision. The waxing and waning of his original symptoms early on in treatment supports this idea. Third, Mr. and Mrs. P. were both committed to the treatment and readily and sensitively responded to the directive and non-directive interventions of the therapist. Fourth, Fred's awareness of his own unhappiness and discomfort served to motivate him as an active participant in the treatment. Fifth, there existed the push of normal healthy development—the unseen ally of the therapist of children. Fred's new verbal, motor, and interpersonal skills served to bolster his concept of self and to increase his feelings of competence. These factors have provided a fascinating and rich experience for the child psychiatrist gaining entry into the complex emotional world of the troubled small child.

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